Fraud & Abuse Compliance Plan

Clark County, functioning as the Clark County Regional Support Network (CCRSN), is required, in its function as a Prepaid Inpatient Health Plan, to have a Fraud and Abuse Compliance Plan, hereinafter referred to as the "PLAN", in place identifying administrative and management procedures to guard against fraud and abuse. Procedures must include the scope, responsibilities and activities conducted by the CCRSN and reporting procedures. All of CCRSN business shall be conducted in compliance with its Washington State Department of Social and Health Services, Mental Health Division contract, state and federal requirements, all applicable laws and regulations of the United States, the State of Washington, applicable local laws and ordinances and the ethical standards/practices of the industry, as interpreted by the CCRSN.

I. Definitions

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse: Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Persons associated with the CCRSN: All board members, consultants, CCRSN employees, and agencies receiving CCRSN funding directly or indirectly to support mental health services.

Provider: Any individual or entity providing CCRSN funded mental health services through contractual agreement with the CCRSN or a CCRSN Member Government. The term does not include employees of the CCRSN.

Fraud and Abuse can include but not be limited to:

1. Billing for services not performed
2. Double billing
3. Unnecessary services
4. Kickbacks

5. Upcoding (Incorrectly coding a service to one with a higher reimbursement rate)
6. Unbundling (Separating out one service into several, resulting in a higher reimbursement rate)
7. Falsification of health care provider credentials
8. Falsification of provider financial solvency
9. Intentional improper billing
10. Related party contracting
11. Incentives that limit services or referral
12. Embezzlement and theft
13. Billing Medicaid enrollees for CCRSN covered services.

II. Compliance Officer and Committee

A. The Compliance Officer is responsible for overseeing the Fraud and Abuse Plan and coordinating monitoring activities. The Compliance Officer is chair of the CCDCS Compliance Committee and reports to the CCDCS Director. The Compliance Officer always has the right to directly meet with the Director if the circumstances warrant. In consultation with the Compliance Committee and approval by the Director, the Compliance Officer may revise the PLAN, as appropriate. The Compliance Officer duties include the following:

1. Overseeing and monitoring CCRSN compliance activities.

2. Convening the Compliance Committee at a minimum of once a year and on an as-needed basis and reporting to Director on the progress of implementation of the PLAN.

3. Assisting the CCRSN, the Director and the Compliance Committee in establishing methods to reduce CCRSN vulnerability to fraud and abuse.

4. Annually reviewing the PLAN and recommending revisions as necessary.

5. Create an annual work plan to ensure that the CCRSN is functioning in accordance with this compliance plan.

6. At a minimum of once a year reviewing administrative, programmatic and financial monitoring procedures within the CCRSN.

7. Receiving and investigating reports of possible violations of the PLAN.

8. Ensure that corrective action plans are developed to correct violations and prevent future incidents of noncompliance.

9. Ensuring that policies and procedures are developed that encourage employees and contractors to report suspected violations of the PLAN without fear of retaliation.

10. Ensuring that CCRSN Fraud and Abuse Plan is reviewed at least annually.

11. Identifying areas where corrective actions are needed and, in consultation with the Compliance Committee, developing strategies to improve compliance.

12. In cooperation with the Compliance Committee, and as a part of the ongoing monitoring and auditing of the PLAN, ensuring notification of employees and contractors of changes in laws, regulations or policies, as necessary to assure continued compliance.

B. The Compliance Committee is comprised of staff from the CCDCS and the CCRSN. The staff represents the following areas:

1. Business Services

2. Finance

3. Contracts

4. CCRSN Program

5. Quality Management

6. Information Services

III. Monitoring

CCRSN and other CCDCS staff shall make reasonable efforts to detect and prevent fraud and abuse through the following activities:

A Provider site reviews

B. Review of provider quarterly financial information

C. Requirement of annual independent audit

D. Profiling of provider client data

E. Review of community inpatient claims

F. Quality Review Team site visit

G. Ombudsman reports regarding complaints

H. Review of grievances and fair hearings

I. Utilization Management operations

J. Review MHD provider licensing reports

Each year the committee will report on the activities outlined in the annual work plan.

IV. Provider Relations and Contracts

A. The CCRSN does not enter into contracts or other arrangements with providers that, directly or indirectly, pay or offer to pay anything of value, be it money, gifts, space, equipment or services, in return for the referral of consumers by the CCRSN for services paid by the Medicaid program or by any other federal or state health care program.

B. The CCRSN does not enter into financial arrangements with providers that provide additional compensation or incentive payments for:

1. Decreased volume of Medicaid services provided.

2. Reduction or limitation of medically necessary mental health services to Medicaid beneficiaries or recipients of other federal or state health care programs.

C. The CCRSN does not approve nor cause claims to be submitted to the Medicaid program or any other federal or state health care program for:

1. Services provided as a result of payments made in violation of (A) above.

2. Services that are not reasonable and necessary.

3. Services that cannot be supported by the documentation in the medical record.

D. The CCRSN does not falsify or misrepresent facts concerning the delivery of services or payment of claims in connection with the Medicaid program or any other federal or state health care benefit program.

E. The CCRSN employee, or person associated with the CCRSN, cooperates with the Compliance Officer in the communication of information or records related to violation of the PLAN.

F. Agencies, agency employees or subcontracted or individuals listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation, as required by current federal and state laws, or found to have a conviction or sanction related to health care will be excluded from providing the CCRSN funded services.

V. CCRSN Provider Responsibilities

A. Providers are encouraged to develop internal compliance plans.

B. Providers implement procedures to screen employees and subcontractors to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation as verified through the United States Health and Human Services website at http://exclusions.oig.hhs.gov. and the Excluded Parties Listing System at http://www.epls.gov. Employees or subcontractors found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with, CCRSN funded services.

C. Providers are required to report all incidents of abuse and fraudulent activities to the CCRSN Compliance Officer per section IX.

D. Providers are required to certify their data monthly, including a general certification that they are in substantial compliance with the terms of the contract.

VI. Education and Training

A. Contractors are made aware of their obligation to report to the CCRSN their good faith belief of any possible instances of non-compliance through terms identified in the CCRSN Statement of Work.

B. The Fraud and Abuse Compliance Plan and reporting requirements are referenced in CCRSN contracts and provided as an attachment. Contractors are made aware of their obligation to report to the CCRSN their good faith belief of any possible instances of non-compliance.

C. The CCRSN will notify subcontractors of applicable fraud and abuse training opportunities offered through Center for Medicare and Medicaid Services (CMS) or the state Mental Health Division (MHD).

D. All CCRSN employees receive a copy of the CCRSN Fraud and Abuse Compliance Plan in addition to information and/or notification of training opportunities on their responsibilities to report non-compliance. Information and/or training will address the following:

1. The CCRSN's Commitment to compliance with all laws, regulations and guidelines of federal and state programs.

2. The elements of the Fraud and Abuse Compliance Plan.

3. An overview of what constitutes fraud and abuse in a Medicaid Managed Care environment.

4. A review of the specific state contract requirements applicable to CCRSN business.

5. The consequences of failing to comply with applicable laws.

6. CCRSN Fraud and Abuse Policy and Procedures.

IX. Developing Effective Lines of Communication

A. An open line of communication between the Compliance Officer and employees, providers, or others associated with the CCRSN is critical to the successful implementation and operation of the PLAN.

1. All employees and providers associated with the CCRSN have a duty to report all incidents of abuse and fraudulent activities to the Compliance Officer.

2. A report is made in any of the following ways:

a. In person to the Compliance Officer.

b. By faxing the Compliance Officer at (360)397-6028.

c. By calling, on an anonymous basis, the Compliance Officer at (360)397-2130.

d. By mailing a written concern to:

Compliance Officer
Clark County Department of Community Services
P.O. Box 5000
Vancouver, WA 98666-5000

3. In addition, any person may seek guidance with respect to the PLAN at any time by following the same reporting mechanisms outlined above.

B. The process for an investigation of a report is as follows:

1. Upon notification of a suspected instance of non-compliance the Compliance Officer will conduct an initial investigation. If it appears there are genuine compliance concerns, the Compliance Officer informs the Compliance Committee, the Director and the MHD.

2. The Compliance Officer presents the recommended corrective action plan to the Compliance Committee. The Compliance Officer, after consideration and any modification, forwards the corrective action plan to the Director for approval. A copy of the approved plan is submitted to the Mental Health Division and the Compliance Officer and Compliance Committee develop a strategy for implementation of the corrective action plan, with the advice and guidance of legal counsel. The corrective action plan is designed to ensure that the specific violation is addressed and, to the extent possible, that a similar problem does not occur in other departments or areas; appropriate education activities are included.

   a. If the investigation reveals possible criminal activity, the corrective action plan includes:

      (i) Immediate cessation of the activity until the corrective action is in place.

      (ii) Initiation of appropriate disciplinary action against the person or persons involved in the activity, including removal from direct responsibility for, or involvement with, CCRSN funded services.

      (iii) Notification to such law enforcement and regulatory authorities as legal counsel advises, which at a minimum includes, for Medicaid fraud, notification to the Medicaid Fraud Unit of the Washington Attorney General's Office and the Director of the Managed Care Contracting Division of the Department of Health Care Policy and Financing.

      (iv) Appropriate education of employees and those associated with the CCRSN to prevent future similar problems.

      (v) Initiation of any necessary action to ensure that no consumers are placed at clinical risk.

   b. If the review results in conclusions or findings that the activity is not a violation of the PLAN or that the activity did not occur as alleged, the investigation is closed.

C. Any threat of reprisal against a person who makes a good faith report under the PLAN is against CCRSN policy. Reprisal, if found to be substantiated, is subject to appropriate discipline, up to and including termination, in accordance with the entity's human resources policies and procedures.

D. Any attempt to harm or slander another through false accusations, malicious rumors or other irresponsible actions is a violation of CCRSN policy. Such attempts, if found to be substantiated, shall be subject to discipline, up to and including termination, in accordance with the entity's human resources policies and procedures.

E. The CCRSN, at the request of a reporting person, shall provide such anonymity to the reporting person as is possible under the circumstances in the judgment of the Compliance Officer, consistent with the CCRSN's obligation to investigate concerns and take necessary corrective action.

F. If the identity of the complainant is known, the Compliance Officer provides a written report to the reporting individual that an investigation has been completed and, if appropriate, the corrective action that has been taken.

X. Enforcement Through Disciplinary Measures

A. Employee Discipline

The CCRSN will initiate appropriate disciplinary action against the person(s) whose conduct appears to have been intentional, willfully indifferent or with reckless disregard of state and federal laws, in accordance with the County's human resources policies and procedures.

B. Contractor Discipline/Termination

CCRSN contracts include provisions which require compliance with the PLAN and clearly state that breach of these provisions will be events for corrective action or termination of the contract after failure to cure.